DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION SURVEY REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code

6. Medicaid Provider No.	7. Name of CEO	8. Telephone No. W1

9. State/Region code W2	10. State/County code W3	11. Dates of Survey (Begin) Month / Day / Year W4	(End) Month / Day / Year W5

12. Type of Ownership or Control (enter number in box below) W6

☐
1. Private (non-profit)
2. Private (proprietary)
3. State
4. City/Town
5. County
6. City/County
7. Other *(specify)* _____

13. Is this ICF/MR a distinct part of a Hospital, SNF or NF? W7

☐ Yes ☐ No

14. If "Yes" to block 13, indicate either W8

A. Hospital Provider No. .....
B. SNF Provider No. .....
C. NF Provider No. .....

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in column 1 represented on the Survey team, indicate the number who also qualify as a QMRP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse		
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify) _____		
N. Total number of Surveyors onsite	W11	
O. Total number of QMRP Surveyors onsite	W12	

16. Facility Data:

A. Is this ICF/MR a residential unit within a larger organization or agency in the State that provides residential services to persons with mental retardation? *(check one)* ☐ Yes ☐ No
If *"No"*, proceed to item C. W13

B. If *"Yes,"* indicate name and address of larger organization.

Name

Address

City | State | ZIP Code

Name of CEO

Total Number of Beds	W14
Total Number of Clients *(including ICF/MR clients directly served)*	W15
C. Total Number of ICF/MR Clients	W16
D. Is this ICF/MR community-based? *(check one)* ☐ Yes ☐ No	W17
E. Total number of ICF/MR beds under this Provider No.	W18
F. Total number of discrete living units under this Provider No.	W19
G. Age range of clients served *from* ___ *to* ___	W20 / W21
H. Total number of off-campus day program sites used by ICF/MR clients	W22

17. Staffing: List the full time equivalents who function in this capacity:

A. Direct Care Personnel (483.430(d)(3))	W23
B. Registered Nurse (483.480(d)(3))	W24
C. Licensed Voc./Practical Nurse (483.480(d)(2))	W25
D. Total Personnel *(List the Full Time Equivalent for all employees)*	(W26)

18. Off-Campus Day Programs:

A. How many clients in the sample attend off-campus day programs?	W27
B. In how many off-campus day program sites was an observation done by the Surveyor?	W28

20. Individual Characteristics *(Note: The total number in Items B-L (Col.(a)) may exceed the facility's population because some clients have multiple disabilities)*

A.

(1) Age

under 22(a) W29

22-45 (b) W30

46-65 (c) W31

66+ (d) W32

[redacted] Total W33

(2) SEX

Male W34

Female W35

[redacted] Total W36

B. DISABILITIES

(1) Mental Retardation

Mild W37

Moderate W38

Severe W39

Profound W40

[redacted] Total W41

(2) Autism W42

(3) Cerebral Palsy W43

(4) Epilepsy

Controlled W44

Uncontrolled W45

[redacted] Total W46

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile W47

Non-Mobile W48

[redacted] Total W49

(2) Speech/Language Impairment W50

(3) Hearing Impairment

Hard of Hearing W51

Deaf W52

[redacted] Total W53

(4) Visual Impairment

Impaired W54

Blind W55

[redacted] Total W56

D. MEDICAL CARE PLAN W57

E. DRUGS TO CONTROL BEHAVIOR W58

F. PHYSICAL RESTRAINTS W59

G. TIME-OUT ROOMS W60

H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI W61

I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS W62

J. NUMBER OF COURT ORDERED ADMISSIONS W63

K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT W64

L. OTHER *(specify)*

(1) W65

(2) W66

(3) W67

M. ALLEGATIONS OF ABUSE AND NEGLECT

no. of allegations of abuse investigated (a)	W68
no. of allegations of neglect investigated (b)	W69
[redacted] Total	W70

N. NUMBER OF DEATHS

no. of deaths related to unusual incidents (a)	W71
no. of deaths related to restraints (b)	W72
no. of deaths for any reason (c)	W73
[redacted] Total	W74